**Supplementary File 3**

Surgical treatment for breast cancer has been improved, and data from the NSABP B04 study showed that survival after modified radical mastectomy was consistent with that after radical mastectomy [1]. The NSABP B06 study and the Milan study confirmed that there was no statistically significant difference in overall survival between mastectomy and breast-conserving surgery combined with radiotherapy [2,3]. Therefore, breast-conserving surgery and modified radical mastectomy are currently the mainstream surgical methods in clinical practice. Data from the Chinese Society of Breast Surgery-005 (CSBrS-005) study showed that the rate of breast-conserving surgeries in China was 14.6% [4]. In view of the advantages of minimal trauma and high quality of life after breast-conserving surgery, as well as the support of high-level evidence, the panel recommended breast-conserving surgery as the preferred choice for treatment of breast cancer in patients with breast-conserving qualifications. Axillary staging of breast cancer can help predict the prognosis and guide subsequent treatment. The results of the NSABP B32 study indicated that patients with negative sentinel lymph nodes can be exempted from axillary lymph node dissection [5,6]. The panel recommended sentinel lymph node biopsy as the preferred surgical procedure for axillary staging of cN0 early breast cancer.

For patients undergoing breast reconstruction after mastectomy, skin-sparing mastectomy (SSM) and nipple-sparing mastectomy (NSM) can provide adequate skin coverage for subsequent breast reconstruction and achieve a better appearance. A meta-analysis of 20 studies showed that NSM does not affect tumor safety in patients with breast cancer and is a safe surgical procedure in patients with early breast cancer [7]. Because the safety data of NSM and SSM are mostly based on retrospective analyses, the panel recommends that NSM/SSM should be considered only for patients who require breast reconstruction and meet strict indications. For patients who undergo mastectomy and require breast reconstruction, the reconstruction schedule should be selected according to the patient’s condition, breast appearance, and physical condition [8]. When determining the timing of reconstruction, the clinician must consider the interaction between adjuvant therapy and reconstruction of the breast. The sequence of radiotherapy and breast reconstruction is controversial, and different treatment sequences have advantages and disadvantages [9]. The panel believes that tumor safety should be considered as the most important factor in making treatment decisions.

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